STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		A. BUILDING:		С		
		IL6008130	B. WING		03/28/2019	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, ST	FATE, ZIP CODE		
GENERA	TIONS AT ROCK ISLA	AND 2545 24TH				
		ROCK ISL	AND, IL 612			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (X5) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETE DATE		
S 000	Initial Comments		S 000		4	
	Initial Complaint Inv	restigation 1922084/IL110634				
	Licensure violations	3				
S9999	Final Observations		S9999			
	300.610a) 300.1210b) 300.1210d)2)5) 300.3240a)					
	Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.					
	Nursing and Person b) The facility scare and services to practicable physical well-being of the reseach resident's con plan. Adequate and care and personal of resident to meet the care needs of the res	General Requirements for hal Care shall provide the necessary of attain or maintain the highest I, mental, and psychological sident, in accordance with apprehensive resident care I properly supervised nursing care shall be provided to each te total nursing and personal esident. Restorative ude, at a minimum, the		Attachment Statement of Licensure		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

TITLE

(X6) DATE 04/18/19

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
IL6008130		B. WING		C 03/28/2019		
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OFNED	71010 17 0001	25/15 2/TL		77A7E, 21F 00DE		
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S9999	Continued From pa	ge 1	S9999			54
29999	following procedured) Pursuant to nursing care shall in following and shall it seven-day-a-week to administered as ord 5) A regular propressure sores, heat breakdown shall be seven-day-a-week to enters the facility widevelop pressure sore clinical condition de sores were unavoid pressure sores shall services to promote and prevent new processores and prevent new p	s: subsection (a), general nclude, at a minimum, the pe practiced on a 24-hour, pasis: Its and procedures shall be lered by the physician. Ogram to prevent and treat at rashes or other skin practiced on a 24-hour, pasis so that a resident who athout pressure sores does not bres unless the individual's monstrates that the pressure able. A resident having I receive treatment and healing, prevent infection, essure sores from developing.	S9999			- Red
		Section 2-107 of the Act) were not met as evidenced				
	interview the facility orders, failed to folio during pressure ulce promote the healing additional pressure tweekly progression and R3) of three resulcers in a sample or esulted in R1 development.	on, record review and failed to follow physician by hand hygiene practices ar dressing changes, failed to and development of alcers and failed to monitor of pressure alcers for two (R1 idents reviewed for pressure of three. These failures oping additional pressure ening of R1 and R3's existing				

PRINTED: 05/16/2019 FORM APPROVED

Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: C IL6008130 B. WING 03/28/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **2545 24TH STREET** GENERATIONS AT ROCK ISLAND **ROCK ISLAND, IL 61201** (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) S9999 Continued From page 2 S9999 Findings include: The Facility Pressure Ulcer Treatment and Management Policy, revised 5/17, documents that residents with pressure ulcers will have a physician's order for treatment; a description of the wound will be maintained on a weekly basis; the licensed nurse will document the treatment as given on the Treatment Administration Record: and the licensed nurse will perform the treatment utilizing standard precautions for infection control. The Pressure Ulcer Prevention Protocol Policy, revised 5/18, documents that daily skin checks conducted by either the Certified Nursing Assistant or Licensed Nurse to ensure early identification of potential problem areas; and that residents will have their skin checked and documented utilizing the Treatment Administration Record; and the skin check will be performed at a minimum of weekly. The Facility Bath Policy, revised 5/17, documents that the resident is to be cleansed and refreshed at least weekly by providing one complete bath and hair wash; and to follow physician's orders for wound care; and documentation of wound care must be completed each time the treatment is done and will be done on the Treatment Administration Record/TAR. The Facility Handwashing Policy, undated, documents that handwashing shall be regarded by this organization as the single most important means of preventing the spread of infections; all personnel shall follow our established handwashing procedures to prevent the spread of infection and disease to other personnel, patients and visitors; handwashing must be performed before handling clean/soiled dressings, after

FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: C B. WING IL6008130 03/28/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **2545 24TH STREET GENERATIONS AT ROCK ISLAND** ROCK ISLAND, IL 61201 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5)(EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) S9999 Continued From page 3 S9999 handling used dressings, after contact with body fluids and upon completion of a duty; and the use of gloves does not replace handwashing. 1. R1's Physician Order Sheet, 3/26/19. documents pressure ulcer treatment orders for R1's Left Posterior Thigh (cleanse with saline/wound cleanser, apply dressing [Triad] and cover wound with border dressing every other day and as needed); Left Proximal Medial Buttock (cleanse with saline/wound cleanser, apply dressing [Triad], cover with border foam every other day and as needed; Left Proximal Posterior Thigh (cleanse with saline/wound cleanser, apply dressing [Triad], cover with border foam every other day and as needed; Right Ischium (cleanse with saline/wound cleanser, apply calcium alginate to wound bed, cover with pad, daily); and Right Medial Buttock (cleanse wound with saline/wound cleanser, apply dressing [Triad] and cover with border foam every other day and as needed. R1's Care Plan documents to treat per Physician Orders, conduct a systematic skin inspection daily and to check and change during routine rounds every 2 hours and as needed. R1's Treatment Administration Record/TAR, dated 2/1/19 through 3/22/19, does not document treatment administration to R1's Coccyx/Buttocks and Right Ischium on 2/5/19, 2/6/19, 2/7/19, 2/9/19, 2/10/19, 2/11/19, 2/16/19 2/18/19. 2/19/19, 2/20/19, 2/22/19, 2/24/19, 2/25/19,

3/13/19 and 3/21/19.

2/26/19, 2/27/19, 2/28/18, 3/1/19, 3/3/19, 3/4/19, 3/5/19, 3/6/19, 3/7/19, 3/8/19, 3/11/19, 3/12/19,

R1's Wound Clinic Assessment Details, dated 1/24/19, documents R1's Right Ischium Pressure

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
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NAME OF	PROVIDER OR SUFFLIER			TATE, ZIP CODE		
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(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES			011	
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE	
S9999	Continued From pa	ge 4	S9999			
	Ulcer with an onset measurements of 0 0.1 cm.	of 6/14/18 and .2 centimeters/cm X 1.2 cm X				
	R1's Wound Clinic Assessment Details, dated 2/25/19, documents R1's Right Ischium Pressure Ulcer measurements of 0.4 cm X 2.7 X 0.1 cm. R1's Facility Skin Assessment, dated 3/10/19, documents four pressure ulcers on R'1 left buttock/ischium measuring 3.9 cm X 1.4 cm, 2.0 cm X 1.0 cm, 5.4 cm X 1.0 cm and 3.7 cm X .7 cm; and on two pressure ulcers on R1's right buttock/ischium measuring 1.8 cm X 1.9 cm x 1.5 cm and 4.5 cm X 2.0 cm; and a pressure ulcer on R1's left posterior thigh measuring 4.5 cm X 2.0 cm.					
	2/13/19, documents	Pressure Injury Report, dated one pressure ulcer, R1's suring 1.2 cm X 0.4 cm X 0.1				
	3/25/19, documents Right Ischium (onse 5.5 cm X 7.5 cm X1 Thigh (acquired 2/20.5 X 0.2 cm; and Lo	Assessment Details, dated four pressure ulcers to R1's at 6/14/18) measurements of .7 cm; Left Proximal Posterior 5/19) measurements of 1.0 X aft Proximal Medial Buttock measurements of 1.6 cm X		50		
		document R1's shower /1/19 through 3/25/19.				
	dated 2/13/19 through	Pressure Injury Reports, gh 3/27/19, were not ocumentation could be ility.				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
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IL6008130			B. WING		03/28/2019	
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, ST	ATE, ZIP CODE		
GENER	ATIONS AT ROCK ISLA	AINIII	H STREET			
		ROCK ISL	_AND, IL 6120	<u>)1 </u>		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (X5) (EACH CORRECTIVE ACTION SHOULD BE COMPLETE CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY)		
S9999	999 Continued From page 5					
	On 3/27/19, at 1:30 pm, V6 (Licensed Practical Nurse/LPN) performed pressure ulcer care to R1. R1 performed hand hygiene and applied clean gloves and performed R1's Left Proximal Medial Buttock, Left Proximal Posterior Thigh and Left Posterior Thigh pressure ulcer treatment. With the same gloves, V6 picked up a tube of medicated cream (Triad) that had fallen onto the floor, and placed it back onto the bedside table. Then with the same gloves, V6 cleansed R1's Right Ischium and Right Medial Buttock pressure ulcers and discarded the soiled dressings into the trash bag that was laying on the floor next to R1's bed. V6 then applied the same medicated cream (Triad) with a cotton tip applicator to R1's Right Medial Buttock and Right Ischium. No hand hygiene was performed. V6 removed the soiled gloves into the trash bag on the floor and put on a new pair of gloves. No hand hygiene was performed. V6 then positioned R1 in the bed.		S9999			
	usually wash my ha and remove the old hands. Then I do the off my gloves and we not usually do her dependent of the wound nurse does to the control of the c	pm, V2 (Director of d, "We have not been doing or treatments as ordered, the not getting done, the weekly nd weekly Facility Pressure not been done since 2/13/19." pm, V4 (Would Clinic			VI	

FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: C B. WING IL6008130 03/28/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **2545 24TH STREET GENERATIONS AT ROCK ISLAND ROCK ISLAND, IL 61201** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX EACH CORRECTIVE ACTION SHOULD BE PREFIX COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) S9999 Continued From page 6 S9999 or the ulcers will get worse." 2. R3's current Minimum Data Set Assessment, dated 2/23/19 documents under Section M0300 Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage: (1) Stage 4 wound. R3's current (local) Wound and Hyperbaric Institute Wound Notes, dated 2/25/19 document. "Left Ischial, Stage 4 Pressure Injury, measuring 1 CM (centimeter) X 0.3 CM X 0.5 CM with no tunneling." This same document includes the following physician orders: "Cleanse wound with non-cytotxic agent. Apply Barrier Ointment (Baza Cream) to protect surrounding skin to wound daily. Pack wound with Medihoney. Cover wound and secure dressing in place. Change dressing every other day and as needed. May shower two times a week. Wound must be kept covered and dry with (occlusive dressing)." Additional orders include,"Follow up appointment, return in 1 month. Use wheelchair cushion. Mattress Overlay or Speciality Bed or Mattress. Follow a nutritious diet. Dietary supplement-Increase Prostat 30 ML (milliliters) per dose to three times daily, mix with soda pop or juice." R3's current Physician Order Sheet, dated March 2019 includes the following physician's order: (1/28/19) MediHoney paste apply to left ischium

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included.

then cover with border foam dressing daily. The Wound Clinic Physician orders for cleansing the ischial wound, application of the protective Barrier Cream and dietary protein supplements are not

R3's current Care Plan, dated (revised) 12/13/18 includes the following Problem: (R3) has a pressure ulcer, stage 4 on left ischium. Included

FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CL!A (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: C B. WING IL6008130 03/28/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **2545 24TH STREET GENERATIONS AT ROCK ISLAND** ROCK ISLAND, IL 61201 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5)(EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) S9999 Continued From page 7 S9999 under Approaches for staff are: MediHoney paste to left ischium daily and Assess the pressure ulcer for location, stage, size (length, width, depth), presence/absence of granulation tissue and epithelization weekly. R3's Treatment Administration Record, dated 2/1/19-2/28/19 documents R3's treatment was not completed 12 out of 28 days for the month of February. On 3/28/19 at 1:00 P.M., V2/Director of Nurses verified staff failed to perform R3's treatment as ordered by the physician, failed to apply protective barrier cream and failed to provide R3 dietary protein supplements. On 3/26/19 at 9:35 A.M., V3/Registered Nurse (RN) prepared to perform wound care to (R3's) left ischium. V3/RN washed hands, applied gloves and removed the old dressing from R3's left ischium. V3/RN cleansed the area with wound cleanser and applied a border foam dressing smeared with Medihoney to the area, V3/RN did not apply barrier cream to the surrounding skin or pack the ischial wound with Medihoney. On 3/26/19 at 12:20 P.M., V2/Director of Nurses (DON) performed wound measurements to R3's left ischium. The area currently measures 5 CM X 3 CM X 2 CM with tunneling of 1.8 CM at 10:00 o'clock, 1 CM at 12:00 o'clock and 1 CM at 1:00 o'clock.

On 3/27/19, at 9:50 am, V5 (Medical Director/R1's Physician) stated, "That is absolutely wrong if they are not doing the

treatments. They should be doing the treatments as ordered, regardless if there is a wound nurse in the facility or not. That definitely can affect the

PRINTED: 05/16/2019 **FORM APPROVED** Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING: __ COMPLETED IL6008130 B. WING_ 03/28/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **2545 24TH STREET GENERATIONS AT ROCK ISLAND** ROCK ISLAND, IL 61201 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID. (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) \$9999 Continued From page 8 S9999 wound progress." (B)